Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

Preferred Drug List Exception Request
PRIOR AUTHORIZATION REQUEST FORM

Patient Name (Last) (First) MI	**MS Medicaid 9 Digit ID #:**	**Date of Birth**

Practitioner Name (Last) (First) (M I)	**NPI#** **Medicaid ID #**
Practitioner Address (Street) (City) (State) (Zip)	**Phone #** **Fax #**

Pharmacy Name & Address (City) (State)	**Provider Number**	**Phone#** **Fax #**

Non-Preferred Drug Requested	**Dose Directions**	**Phone#** **Fax #**

Diagnosis (Optional) Diagnosis Code (ICD-9-CM)

Please answer each of the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred products(s)? Yes No

1st Drug _____ Length of Therapy_____Reason for D/C_____

2ndDrug_____ Length of Therapy_____Reason for D/C_____

Attach additional documentation of other treatment failures with preferred drugs if necessary.

2. Does the patient have a condition that prevents the use of the preferred products(s)? Yes No

If YES, list the interaction(s) in the box below:

3. Is there a potential drug interaction between another medication and the preferred products(s)? Yes No

If YES, list the interaction(s) in the box below:

4. Has the patient experienced intolerable side effects while on the preferred product(s)? Yes No

If YES, list the side effects in the box below:

MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.

Practitioner Signature: _____Date:_____